# MEDICINE.

UNDER THE CHARGE OF

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## MALTA (REMITTENT) FEVER.

GADDING (*British Medical Journal*, 1891, No. 1585) gives an analysis of forty-two cases occurring on H. M. S. Agamemnon.

The writer describes three types: Enteric type, always severe and generally supplying the fatal cases. Remittent type, with high initial temperature, marked remissions and tendency to relapses. Hybrid type, supplying 60 per cent of the cases. The primary attack is often trivial and of short duration. Rheumatism of an obstinate character is a common sequela and relapses of a severe nature are common. These cases are variously described as "Malta fever," "sweating fever," "typho-malarial," and "undefined climatic fever."

Etiology: The disease commences almost invariably in the spring. A few cases followed exposure to a hot sun. In four cases trifling injuries, bruises, and sprains appeared to determine the attack. Exciting causes: Malarial poison plays an important part, but true ague is not often seen. The disease is no doubt largely filth-produced, and improved drainage and water supply have lessened the virulence of type. The poison concentrates its force on the lymphoid structures of the alimentary canal (tonsils and Peyer's patches), thus accounting for the resemblance to typhoid fever; but the disease must not for this reason be assumed to be typhoid.

Duration: One week to six or seven months. Only eight made perfect recoveries, and were from one to six weeks under treatment. No eruption was noted in any case.

Symptoms and complications: Acute orchitis was noted in seven cases. Rheumatism occurred in nearly all at some period of the attack, and was often a troublesome sequela. Pneumonia was observed in three cases, the signs rapidly clearing in two. One death occurred from secondary pneumonia.

Diagnosis: The majority of cases point strongly to a malarial origin. The chief points of difference from true "remittent" are: (1) absence of splenic and hepatic enlargement; (2) powerlessness of quinine to cure, and (3) character of the complications—rheumatism, orchitis, tonsillitis, etc. The disease really defies all treatment. The one efficient remedy is change of climate.

In the opinion of SURGEON DAVID BRUCE, M.S., founded on an experience of 400 cases in the Military Hospital at Valetta, Malta fever is in no sense a

malarious fever; it is a species of fever perfectly distinct from enteric or malarious fever, having its own definite parasitic cause, and is as worthy of specific recognition as diphtheria or tuberculosis. The writer states that in every fatal case of true Malta fever a definite microörganism is demonstrable which has not the slightest resemblance to the amœba-like parasite of malaria. It can be cultivated with the greatest ease from the spleen and other organs, and has never been found in the organs of cases of malarious fever or any other disease. No description is given of the microörganism in question.

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### Double Empyema.

Handford, of Nottingham (*British Medical Journal*, 1891, No. 1585), reports the case of a boy, aged seven and a half years, in whom double empyema followed on an illness of three weeks' duration. The left chest was opened and three-quarters of an inch of rib removed. Dyspnœa was much relieved by the evacuation of pus. Ten days later the right chest was emptied in a similar way. Both tubes were left out at the end of nine weeks, and the patient made an excellent recovery.

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### Fibroid Pneumonia.

Auld, of Glasgow (*Lancet*, 1891, Nos. 3537 and 3538), under this title describes two cases of an affection of the lungs which "has only within recent years begun to be recognized." The affection is in no way connected with those variously known as chronic broncho-pneumonia, chronic pleurogenous pneumonia, pneumo-koniosis, and phthisis pulmonalis.

Anatomically, though not clinically, the disease is identical with chronic pneumonia succeeding acute pneumonia. It has also been termed "parenchymatous pneumonia," or "primary indurative pneumonia." Cases of this disorder have been described by Ludwig Bühl, in 1872, and M. Heitler, in 1884, and also by Eppinger, Wagner, and Talma. English medical literature contains a few isolated examples.

From the consideration of his two cases, together with the indications afforded by those quoted above, the author concludes—(1) that there is a pneumonia, a lobar affection of the lungs, insidious in its origin and subacute or chronic in its course, characterized essentially by induration of a creeping fibrinous exudation and by interstitial changes, and accompanied by proliferation and fatty degeneration of the pulmonary epithelium, and also not unusually of the bronchial epithelium; (2) that anatomically the disease is in every respect identical with chronic pneumonia succeeding an acute attack; and (3) that the morbid anatomy of the disease has in its earlier stages such distinctive and unequivocal features as to give the affection an assured position and to permanently exclude the possibility of confounding it with any other chronic affection of the lungs. Insomuch as this disease—whether preceded by an acute pneumonia, or being chronic from the first—has as its leading feature the development of a nuclear fibrous tissue in, with, and about a pneumonic exudation, it is most fitly termed "fibroid pneumonia."

The subacute cases usually terminate fatally in about six weeks, after run-

ning a course not unlike that of acute phthisis. Tubercle, when present, is limited. In one of the author's cases there was no tubercle, and the bronchial pus contained the capsulated diplococcus pneumoniæ. In the other case there was apical cicatrix and adhesion, with included cretaceous matter and general fibrosis of other organs.

In the writer's opinion it is chiefly, if not exclusively, after an acute onset that fibroid pneumonia may assume the chronic type. The subacute cases are distinguished from chronic broncho-pneumonia by their comparatively short duration; but there are admittedly great difficulties in the way of making a clinical diagnosis of this disease, among which may be mentioned its rarity and the similitude in general of its physical signs and symptoms to those of phthisis.

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### Points of Affinity between Rheumatoid Arthritis, Locomotor Ataxia, and Exophthalmic Goitre.

Spender (*British Medical Journal*, 1891, No. 1587) mentions that nearly every case of rheumatoid arthritis in early or middle life shows marks of cerebral sympathy in one or more ways: pigmentation, sweating, tachycardia or high tension, neuralgia. Pigmentation is common, and of various hues. A bronze smear across the forehead, dark streaks beneath the lower eyelids, or staining of the cheeks or neck are met with: discolorations which closely resemble those occurring in exophthalmic goitre. Leucadermia is met with in both diseases. Discoloration of the skin is, however, rarer in arthritis than in exophthalmic goitre.

Tachycardia is a not uncommon feature of early cases of arthritis. In nine out of eighteen cases of undoubted rheumatoid arthritis the average pulse-rate was above 90. The heart's action was not accelerated by emotion or moderate exercise. There were no murmurs. Venous hum was frequent. Attention is drawn to the occasional coincidence of thyroid enlargement in rheumatoid arthritis, especially where there is a dark stain on the neck.

Tremor and muscular spasm are common to both diseases, though far less frequent in arthritis.

Functional disturbance of the pneumogastric nerve is an important bond between arthritis and locomotor ataxia. Gastric crises, cramps of the stomach and vomiting, a pseudo-asthma, or a transient dyspnœa and difficulty of swallowing may occur in the early stages of both diseases. But the closest analogy between them is in the nature and character of the pain. The author inclines to the view that rheumatoidal and Charcot's joint lesions are identical.

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### Bradycardia, or the Slow Heart.

Seymour Taylor (*British Medical Journal*, 1891, No. 1589) says: Bradycardia is defined as being that condition in which the heart-beats do not exceed forty per minute. A classification of causes is difficult, owing to the wide pathology and varied associations; hence he proposes to subdivide the cases into two headings: *A*. Occurring in health; *B*. Occurring in disease. (*A*.) As regards health. It frequently occurred in tall, muscular men, who were or had been athletic in their habits. In them it was not inconsistent

with prolonged life and great mental vigor. It was important to note that in such examples the bradycardia was not attended with dyspnœa. It was not infrequently an accompaniment of old age, but an age which might be attended with no other sign of decay or degeneration. There was also a group of cases which, for want of a better term, might be called "functional." They were usually an accompaniment of indigestion, or some other disorder of stomach or other organ. They were temporary only, and were not attended with any signs of heart lesion. (*B.*) Cases the result of disease. Here the assertion that disease tended to quicken rather than to lessen the heart's action was admitted. Yet there were some disorders which produced an opposite effect. For example, it was occasionally seen in (1) disease of the heart-walls; (2) obstruction of coronary vessels; (3) as a sequel of certain fevers and blood diseases; (4) in relation with diseases of the respiratory beat and mechanism; (5) as a manifestation of grave neurotic changes—epilepsy, traumatism, etc.; (6) in abdominal injuries and operations; (7) as the result of certain drugs and poisons.

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### Senile Chorea; Mania; Recovery.

Ferrier (*Lancet*, 1891, No. 3538) records the case of a woman, aged seventy years, who had an attack of left-sided chorea in 1890. The present attack affected the right side and began at Christmas-time with a severe bilious attack, and was accompanied by great irritability of temper and sleepnessness.

On admission to hospital there was typical chorea of the right side. The thoracic and abdominal viscera were healthy. The same night the patient became acutely maniacal and had to be isolated and put into a straight waist-coat. She was taken home after three weeks in practically the same condition. About nine weeks later the chorea began to subside, and the condition of cerebral excitement rapidly passed off. The treatment consisted mainly in the administration of bromide of potassium, arsenic, and quinine.

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### On the Treatment of Intussusception by Injection or Inflation.

Mortimer (*Lancet*, 1891, No. 3534), while fully admitting certain obvious advantages, draws attention to some of the dangers of this plan of treatment. Inflation does not appear to be safer than injection. An even pressure should be employed in all cases to lessen the chance of exciting peristalsis and rupture. With a view to ascertain the limits of safety of the mode of treatment, post-mortem experiments were made on infants. It was found that when the resultant pressure distending the colon rose to two and a half pounds to the square inch (irrigator raised five feet) there was apt to be cracking of the peritoneum. In some cases there was complete rupture of the bowel at a slightly higher pressure (irrigator at six feet). The writer criticises adversely the conclusions of Dr. W. E. Forest, of New York, in regard to the amount of pressure which it is safe to use.

An interesting case is quoted in which post-mortem experiment was made on a case in which invagination had occurred during life. The subject was an infant aged three months, who presented the usual signs of acute intussusception. Inflation was performed with a Higginson's syringe and the tumor

gradually disappeared. The symptoms recurred after some hours and ended fatally. On examination the stomach and intestines were much distended; there was no peritonitis; the apex of the intussusception was below the splenic flexure. A tube was tied into the rectum and the irrigator raised to two feet. The intussusception was reduced in a few minutes with the exception of one inch; the end of the ileum, the cæcum, and part of the vermiform appendix remaining tightly ensheathed by the colon. After fifteen minutes the irrigator was raised to three feet. A slight further reduction took place, but in four minutes the colon ruptured in three places just below the intussusception.

In another case, in a child aged eight months, about ten ounces of water were injected three times from an irrigator held at three feet, and on the two following days a pint of water was run in at a lower pressure. Post-mortem, three ruptures were found in the descending colon. The writer argues against inflation or injection as a prelude to laparotomy.

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### Cerebral Suppuration following Influenza.

Dr. J. S. Bristowe (*British Medical Journal*, 1891, No. 1592) reports two cases in which the patients were attacked two to three months before death with symptoms indistinguishable from those of influenza.

In the first case, that of a carman, aged twenty-four years, cerebral symptoms came on early and continued with variations and ingravescence to the end. In the second, that of a school-girl, aged fourteen years, headache was an early symptom, but it was only latterly that the symptoms indicated the presence of grave cerebral disease.

The facts which lead the author to conclude that the cerebral abscesses in these cases were referable to influenza are: (1) Acute onset with symptoms indistinguishable from those of typical influenza; and (2) That none of the usual causes of abscess of the brain were or had been present.

In Case 1 the abscess—the size of a small Tangerine orange—was situated in the upper part of the left hemisphere. There was no disease of the ear nor any other condition tending to throw any light on the origin of the abscess. In Case 2 the abscess—which was about the same size—was situated in the right occipital lobe and adjoining part of the sphenoidal lobe. The ears and frontal sinuses were quite healthy.

In an addendum Dr. Bristowe mentions briefly three other cases in which influenza terminated fatally with symptoms of cerebral disease which may have been due to suppuration.

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### The Significance of Cheyne-Stokes Respiration as a Symptom in Cardiac Disease.

Dr. M. A. Boyd reports a case of cardiac hypertrophy and dilatation with systolic aortic bruit in which Cheyne-Stokes breathing occurred, presenting several features of interest.

The phases of the respiratory phenomena observed were as follows:

(1) An apnœal period characterized by deep sleep, lividity of face, quick pulse, feeble contractions of heart, perfect rest from all agitation, mental and bodily.

(2) An inspiratory period, with rousing of all the patient's faculties, extreme restlessness, slowing and strengthening of the pulse, apparently stronger contractions of the heart, less lividity of the face, and then a final deep inspiration.

(3) An expiratory period, with inspirations gradually getting shorter and expirations longer, pulse getting quicker and heart feebler in its contractions until expirations cease and the chest is empty, and restlessness gives place to sleep, which continues through the apnœa following.

The author lays stress on the variations in the pulse or cardiac rhythm during the different periods, and draws attention to the fact that though the respiratory effort during the ascending period is an inspiratory one, during the descending period of the effort it is chiefly expiratory. He is of opinion that the cardiac conditions necessary for the production of this form of breathing are not alone dilatation of the aorta, but also dilatation of the right ventricle with commencing degeneration or weakness of its walls; also hypertrophy of left ventricle with or without dilatation, but with degeneration of its muscle or enfeeblement from any cause, so that it is unable to empty its contents into a dilated and inelastic aorta.—*Dublin Journal of the Medical Sciences*, 1891, No. 235.

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### Influenza Epidemic of 1889–90.

In the official Report just published, Dr. Parsons, who undertook the inquiry, tracks the general course of the epidemic from the northern hemisphere in a direction east and west, and it is explained that this took place mainly against the prevailing winds.

The theory of its relation to some Chinese inundations and of an aërially travelling miasm across the Asiatic and European continents is not borne out by the information procured; but, on the other hand, there is an abundance of evidence to show that it travelled mainly along the lines of human intercourse, attacking large towns and centres of population first, and that the disease travelled only just as fast as any humanly conveyed infection with a similar incubation period might have been expected to travel.

On the question of infection Dr. Buchanan, in his introduction to the report, writes: "Probably no evidence has ever been put on record in such abundance as that accumulated in Dr. Parsons' report, to show that, in its epidemic form, influenza is an eminently infectious complaint, communicable in the ordinary personal relations of individuals with one another. It appears to me that there can henceforth be no doubt about the fact."

Dr. Parsons does not appear to be impressed with the evidence in favor of the existence of any direct relation between influenza and the disease in horses known as "pink-eye."

Over-crowding and impure air must be regarded as having a powerful influence in developing the epidemic, whilst poverty and absence of warm clothing have largely conduced to the fatality of the disease.

The contagium of the disease does not appear to be of a very stable kind, and one characteristic of its instability lies in its uncertain and varying incubation period. Speaking generally, the evidence adduced points to a period of two to three days as the most common period of incubation, and to twenty-

four hours on the one hand, and to some four days on the other, as fairly common extremes.

The poison may find admission into the system through the lungs, but Dr. Bezly Thorne, whose views are quoted at length in the report, is of opinion that the conjunctiva is the structure which the infecting material or microbe most generally, if not always, attacks.

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### The Practical Electro-therapeutics of Graves's Disease.

H. W. D. Cardew, M.R.C.S. (*Lancet*, 1891, No. 3540), is of opinion that many cases in which drugs have proved valueless are amenable to electrical treatment.

For this purpose galvanism is superior to faradism. A very weak current (two to three milliampères) is sufficient. Each application should last six minutes and frequent applications (three times a day) should be made. The anode should be placed on the nape of the neck, the centre of its lower border corresponding to the seventh cervical spinous process, and be firmly held in that position during the application. The kathode should be moved up and down the side of the neck from the mastoid process along the course of the great nerves. The application is followed by a reduction in the frequency and force of the heart-beat, prolongation of the diastole being most marked. The slowing of the pulse-rate does not usually last for more than half an hour. The diminution in violence of beat lasts longer. As the case progresses and improves these effects become permanent.

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### The Treatment of Tuberculosis by Means of Subcutaneous Injections of Eucalyptol, Guaiacol, and Iodoform.

Pignol (*Compt.-rend. hebdom. des Séances de la Soc. de Biol.*, 1891, No. 10) reports that for three years he has applied eucalyptol, alone or in combination with iodoform and creasote or guaiacol; guaiacol and iodoform, without eucalyptol; and creasol and guaiacol, subcutaneously, in the treatment of tuberculosis, with most satisfactory results. He uses as a menstruum sterilized liquid vaselin, olive oil, or oil of sweet almonds—preferably one of the latter two—containing twenty per cent. of the medicaments in varying proportions, of which at least from three to ten cubic centimetres are injected daily. The injections are made with antiseptic precautions into the retro-trochanteric fold. The best results were obtained from a combination of guaiacol and iodoform.

Picot (*Bull. de l'Acad. de Méd.*, 1891, No. 9) has reported the results of treatment in twenty-five cases of pulmonary tuberculosis and eight of pleurisy by means of subcutaneous injections of iodoform and guaiacol, dissolved in sterilized olive oil and vaselin, each cubic centimetre of the solution containing one centigramme of iodoform and five of guaiacol. The injections, each of three cubic centimetres, were made into the supra-spinous fossa daily, and were unattended with unpleasant local results. As an evidence of the absorption of the medicaments, the presence of iodoform could be demonstrated in the urine, guaiacol not being eliminated by the kidneys. As a rule, the

injections occasioned no general reaction, but in certain cases, especially in those with fever, profuse perspiration followed, succeeded in turn by a sense of comfort and a lowering of temperature. In exceptional instances abdominal pain and diarrhœa developed in the course of treatment, but subsided on suspending the injections. In three cases of advanced phthisis, in which death took place, the changes found in the lungs were indicative of a reparative tendency. The tubercles presented an appearance of beginning fatty degeneration; the cavities were clean and dry. In one case the ulcers in the intestine showed a disposition to cicatrization. Neither in the lungs nor elsewhere was there any evidence of a fresh eruption of tubercles as a result of the treatment. In the remaining cases of phthisis the cough diminished, the sputum became less, and the number of bacilli in the sputum smaller, the body weight increased, the night-sweats disappeared, the general condition improved, and the physical signs receded. In the cases of pleurisy the results were equally good. Effusion speedily disappeared, and recovery was rapid.

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### Diabetes and Vascular Sclerosis of the Pancreas.

Lemoinne and Lannois (*Arch. de Méd. expérim. et d'Anat. pathol.*, 1891, No. 1) made a study of the pancreas in four cases of diabetes: three of these belonged clinically to the so-called pancreatic type; one was in a case of long standing. In the last, the liver and kidneys presented alterations similar to those found in the pancreas. In the other three the liver contained several limited areas of interlobular sclerosis not involving the hepatic lobules; the kidneys presented no lesion; the pancreas, however, presented marked changes. In all, the lesions of the pancreas were topographically the same. Sections of pancreatic tissue, hardened in Müller's fluid and stained with hæmatoxylon or carmine, exhibited interacinous and intercellular sclerosis—a true interstitial pancreatitis—having for its point of departure the vascular system and notably the venous and lymphatic system of the gland, and giving rise to consecutive degeneration of the cellular elements. This differs from the conditions found after ligature of the duct of Wirsung, in that the dilatation of the duct is followed by its fibrous transformation, the vascular sclerosis appearing late and as an accessory phenomenon. In the cases in which the pancreatic duct has been ligated the absence of sugar in the urine has been expressly noted. These facts give support to the opinion of M. Lepine that the pancreas, like the liver, has a double function. The liver elaborates not only bile, but also glycogen; the pancreas separates not only trypsin, amylopsin, and steapsin, but also a glycolytic ferment—the first three at the free extremity of the cell, the last at that pole of the cell in relation to the vascular supply.

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### Hemiatrophy of the Tongue of Peripheral Origin.

Before the Canadian Medical Association, at Toronto, Birkett (*Montreal Medical Journal*, 1891, No. 9) reported a case of hemiatrophy of the tongue of peripheral origin. The patient, a bank clerk of twenty-three, nine years

previously, following an attack of mumps, noticed a large and painful swelling behind the angle of the jaw on the right side. Subsequently there was some difficulty in speech, and the tongue, when protruded, deviated to the right. Five years later it was observed that pressure upon the swelling led to flushing and sweating on the right half of the face and to a sense of dryness of the throat. At the time the patient came under observation, when the mouth was opened, the tip of the tongue pointed to the left, but when the organ was protruded, the tip deviated to the right. The right half of the tongue was smaller than the left, and presented reactions of degeneration, but there was no fibrillary contraction, and the sense of taste was unimpaired. There was paresis of the right half of the soft palate, and the mucous membrane of the fauces, soft palate, and walls of the pharynx were insensible to titillation. Sensation, however, was unimpaired at the posterior extremities of the inferior and middle turbinated bones and on the lips and mucous membrane of the mouth. The right vocal band occupied the cadaveric position, scarcely moving in abduction and adduction. Movement of the right half of the epiglottis was defective. The pulse was ninety-six in the minute. The pupil was smaller and the palpebral fissure narrower on the right than on the left. Vision was myopic—on the right by 1 D.; on the left by 0.25 D. From a careful study of the case Birkett believes the lesion to be peripheral, the result of inflammatory changes in and about a cervical gland behind the angle of the jaw and involving the hypoglossal, the vagus, and the accessory nerves, the pharyngeal plexus, and the superior ganglion of the cervical sympathetic—all on the right side. The following deductions are made:

1. The hypoglossal is the motor and trophic nerve of the tongue; 2, the glosso-pharyngeal nerve is concerned in the function of taste; 3, branches of the pharyngeal plexus supply the mucous membrane of the naso- and buccal pharynx with sensory fibres; 4, the motor nerve of the levator palati and azygos uvulæ muscles is probably the accessorius; 5, the superior ganglion of the cervical sympathetic contains (*a*) dilator fibres to the iris of the same side; (*b*) vasomotor fibres; (*c*) sweat fibres; and (*d*) secretory fibres to the mucous glands of the pharynx.

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### Pulmonary Abscess.

In a paper read before the St. Louis Medical Society, Porter (*Journal of the Amer. Med. Association*, 1891, No. 10) expressed the view that pulmonary gangrene or abscess following embolism is not necessarily multiple; that gangrene may follow embolism of a pulmonary artery; and abscess, embolism of a bronchial artery. When the products of disorganization can be readily discharged, with the probability of cicatrization taking place, operation may be deferred; but when there are evidences of rapid breaking down, when fever, restlessness, and depression are marked, prompt and active measures are indicated. When the abscess is extensive and operation necessary, Porter prefers to excise a large piece of rib over the cavity and make a free opening in the pleural sac. A smaller incision may be made in the lung. Two cases of gangrene, successfully operated upon in the manner indicated, are reported.

### Morvan's Disease.

Church (*Journal of the Amer. Med. Association*, 1891, No. 10) reports a case of so-called Morvan's disease, with a brief review of what is known on the subject, the literature of which is scanty. The affection is characterized by a destructive process, progressively and symmetrically involving the digits, ulceration with exfoliation of bone taking place, and resulting in deformity, sometimes preceded by pain and attended with anæsthesia. In the only case of the disease in which an autopsy has been reported, an excess of connective tissue was found in the posterior horns, posterior columns, and gray matter of the cervical cord and in the peripheral nerves. Nothing is known as to its etiology. The disease is to be distinguished from scleroderma, anæsthetic lepra, symmetrical gangrene, and syringomyelia. The treatment is symptomatic.

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### Congenital Occlusion of the Œsophagus; Communication between the Trachea and Œsophagus.

Grandou (*Bull. de la Soc. Anat. de Paris*, 1891, No. 3) reports the case of a newborn infant, which, applied to the breast several hours after birth, took the nipple without difficulty. Each time it nursed, however, the infant became congested and purple; it then abandoned the breast, and almost immediately vomited the milk it had taken. Efforts at feeding with a spoon and gavage were no more successful. Death took place on the sixth day. On examination the superior portion of the œsophagus was found to be normal; lower down was a dilatation an inch and a half in length, below which the œsophagus was replaced by a firm cord, two-thirds of an inch long and a quarter of an inch thick, adherent in front to the trachea. Beyond this the œsophagus resumed its calibre for a distance of a little more than two inches, at its termination emptying into the stomach. Opening the trachea from in front an orifice with bevelled edges, the plane of which looked upward and forward, was found on the posterior wall, a little more than an inch below the cricoid cartilage. This orifice communicated with the lower portion of the œsophagus and through it the mucous membrane of the trachea was continued.

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### Partial Nephritis.

Cuffer and Gastou (*Revue de Médecine*, 1891) describe as partial nephritis a condition succeeding the acute or active manifestations of a renal lesion, in which a fixed and invariable amount of albumin is present in the urine, although the patient is in all other respects in perfect health. Five cases illustrative of the condition are cited. Pathological evidence is wanting, but an analogy is made with the lesions found in amyloid disease, in arteriosclerosis, and in plumbism, in which diseased and healthy structure alternate or the disease is less decided at one part than at another. The condition must be considered not as a disease, but as an infirmity, for which treatment is useless and may prove hurtful. It is important, however, for the patient to avoid those influences which are known to affect the kidneys injuriously.

The prognosis is not grave if appropriate precautions are taken. The conclusions formulated are that persistent albuminuria is a result of a past nephritis, in the chronic stage, and that the persistence of a fixed amount of albumin in the urine, incapable of diminution, is evidence of a partial nephritis.

## SURGERY.

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### STAB-WOUNDS OF THE SPINAL CORD.

DR. OTTO BODE (*Berliner klinische Wochenschrift*, Jahrg. xxviii., No. 22) gives an interesting account of the diagnosis, course, and proper treatment of stab-wounds of the spinal cord. He cites the case of a man who, in a street fight, received several wounds on the head; on the back of the neck there was one about five centimetres long, running obliquely down to the spinal column and exposing at its bottom the atlas and axis. At the moment of wounding the patient fell to the ground, lost consciousness for only a minute, but remained paralyzed on the right side below the point of wounding. When called upon the right lower extremity responded slowly and reluctantly, but for walking or standing was weak and useless. There were no areas of anæsthesia, nor any disturbance of the special senses. The bladder and rectum were normal; priapism not present. The muscles of respiration on the right side were decidedly implicated. The faradic excitability of the muscles remained normal. For three weeks this condition continued apparently unaltered. At the expiration of this time the patient began to gain more and more use of the paralyzed limbs, albeit at the same time the reflexes became greatly exaggerated, and at the least touch the muscles jerked. The patient was under observation for three months; the paralysis was practically gone, and even the reflexes had returned to normal, and in a year's time no evil effects of the wound remained, save at times a slight tremor in the muscles which had been paralyzed. The wound was treated solely by the antiseptic dressings.

From the anatomical relations of the vertebræ and their ligaments, Dr. Bode proceeds to show that in the cervical region when the neck is bent down, as it usually is when a man receives a wound there in a fight, the cord can be wounded at almost any point of its circumference, or, indeed, may be wholly severed, without injury to the vertebræ. From the motor